



PARENTAL AGREEMENT FOR MEDICINES BROUGHT INTO SCHOOL

(Prescribed or continuous Medicines only)

Name of pupil

Name of pupil	
Date of birth	
Medical condition or illness	

Medicine

Name/type of medicine
(as described on the container)

Name/type of medicine (as described on the container)	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – yes /no	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name

Name	
Daytime telephone no.	
Relationship to child	
Address	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff to administer medicine and my child to self-administer medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s):

Date: